Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

Agenda

- Choosing quality metrics
- Using quality metrics
- UnityPoint's data overload

Definition of Quality Metrics

Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.

– Center for Medicare & Medicaid Services

A Quality Metric Is Born

Metrics created by

- NCQA
- Heart Association & other associations
- CMS and other govt agencies
- Research organizations (Mathematica)
- Others

Are used by

- SAMHSA for PBHCI
- CMS for value-based payments
  - PQRS
  - MIPS
- HRSA for FQHCs
- ACOs
- State and local initiatives

***The National Quality Forum has a comprehensive list of quality measures

Physical Health Outcomes

PBHCI

- H indicators – some improvement & no longer at-risk

UDS, PQRS, MIPS

- Controlled hypertension and controlled diabetes

MIPS

- Any improvement from individuals with hypertension

Processes

PBHCI

- H indicators – screen at baseline and reassessment

UDS, PQRS, MIPS

- Tobacco screen and intervention
- BMI screen and follow-up plan

MIPS

- Coordination between providers for comorbid depression and diabetes

Cost Savings (utilization reduction)

PBHCI

- NOMs interview – self-reported ER, nights in jail, nights homeless

ACOs and other geographically-based initiatives

- Reduction in unnecessary ER visits, hospital admittance, hospital admittance for people with specific diagnoses, hospital re-admittance

Consumer Satisfaction

PBHCI

- NOMs Section F

Other payers

- Few examples of satisfaction metrics tied to integrated care

AHRQ has examples of satisfaction scales & questionnaires

Social Determinants of Health

PBHCI

- NOMs Sections B, C and D

Institute of Medicine

- 30 minutes of physical activity 5 times/day.
- Diet conforms with federal dietary guidelines

Robert Wood Johnson Foundation guide to using social determinants of health to improve health care

List of additional wellness measures

Considerations When Choosing Metrics

- Long-term organizational goals/alignment with payers
- The availability of relevant information
- The ability to act on the information

Clinical Quality Measures

Practice Level eCQMs

- HBA1C Poor Control (>9%) (NQF# 0059)
- Medical Attention for Nephropathy Monitoring (NQF# 0062)
- BMI Screening and Follow-up (NQF# 0421)
- Screening for Clinical Depression and Follow-up (NQF# 0418)

Practice Level Behavioral Health focused eCQMs

- HBA1C Poor Control (>9%) (NQF# 0059)
- BMI Screening and Follow-up (NQF# 0421)
- Depression Utilization of the PHQ-9 Tool NQF# 0712)
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (NQF# 1365)
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (NQF# 0104)
- Follow-up after Hospitalization for Mental Illness (NQF# 0576)

LAPTN Level Reporting

- Utilization measures:
  - All-Cause Admissions for Patients with Diabetes
  - All-Cause Admissions for Patients with Depression
  - Reduction of Unnecessary Testing
  - Cost Savings

Using Quality Metrics

- Establish a baseline
- Set a goal for improvement
- Check in periodically to see progress towards goal
- Make changes as necessary to ensure you reach your goal

Using Quality Metrics – Blood Pressure Example

- Choose a metric that aligns with long-term goals
- Build the infrastructure to measure metric & all information necessary to improve the metric
  - List of all people with hypertension (all lists should include demographic information)
  - List of all people with hypertension who have received appropriate care
  - List of people with hypertension who are now below 140/90
- Set target for improvement
- Meet regularly to monitor improvement
- Make changes to workflows/protocols based on conversation during regular meetings

Review Blood Pressure Protocol Guide

https://www.amga.org/wcm/PI/Collabs/HYPE/Compendiums/providence.pdf

Questions?

integration.samhsa.gov

About the Presenter

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Father of 3; Husband of 1

Why I do what I do

Agenda

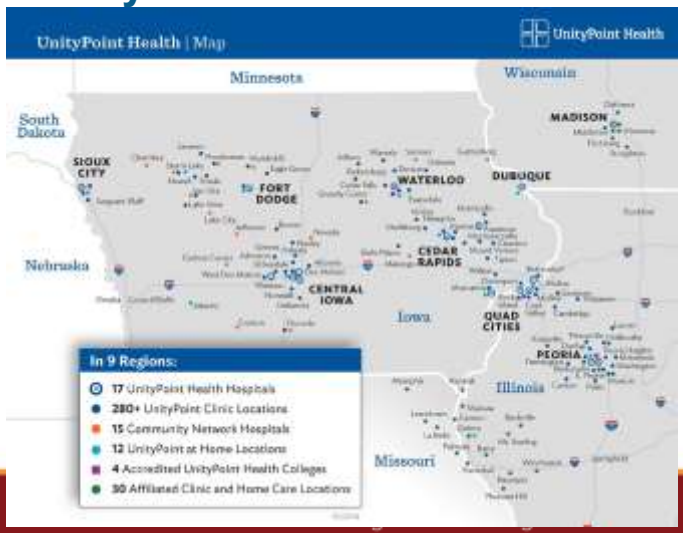
Briefly introduce UnityPoint Health and the Berryhill Center

Define an Accountable Care Organization

Share our journey relating to data within our ACO

Q&A

UnityPoint Health



Strategy: Use our network to own and manage the premium dollar

UnityPoint Health - Berryhill Center

Community Mental Health Center

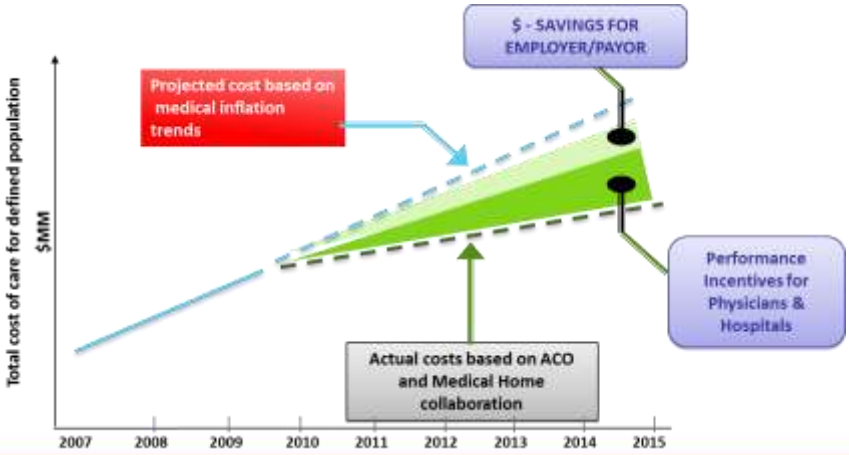
Joined UnityPoint Health in 2008

SAMHSA PBHCI Grantee; Cohort 8

54 Employees; 3 Psychiatrists, 6 ARNPs, & 13 therapists

$5 Million Budget or .1% of UnityPoint Health's total bottom line

Definition of an ACO



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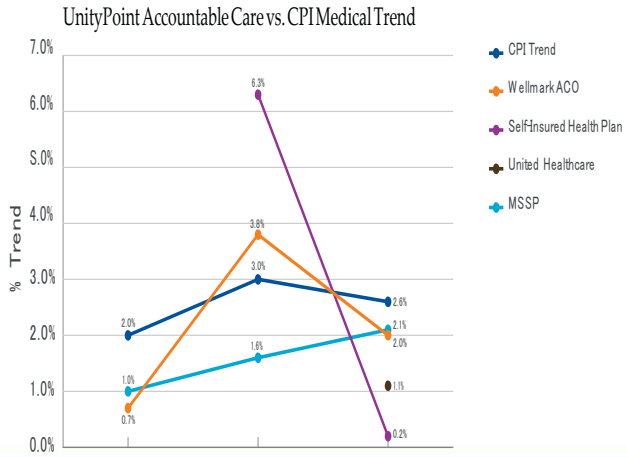
UnityPoint Accountable Care Value-Based Contracts

Value-Based Contract	Covered Lives	At Risk
Medicare Next Generation ACO	70,672	70,672
UnityPoint Health Self-Insured Employee Health Plan	36,870	36,870
Wellmark ACO	142,740	65,255
UnitedHealthcare ACO	67,682	0
Blue Cross and Blue Shield of Illinois ACO	8,087	0
	326,051	172,797

As of June 2016

ACO Performance



ACO vs. MCO

Similarities:
Both "Manage Care of Beneficiaries"
Both involve utilization targets
Both seek to lower health care claim costs

Managed Care Organizations:
Top down approach
Competition among healthcare providers
Designed to remove revenue from healthcare providers

Accountable Care Organizations:
Bottom up approach
Teamwork among healthcare providers
Designed to remove cost from healthcare providers

ACO Contracts pushed us to be more robust in our understanding of data

Multiple data elements as required by ACO Contracts:

- Different metrics for each ACO Contract.
- Created workflows and EHR capabilities to capture data.
- We tried to focus on each individual measure.

ACO Contracts pushed us to be more robust in our understanding of data

Funds Flow Model

- Limit the scope of focus based on areas of opportunity among like organizations (Hospitals, PCPs, Specialists, SNFs and Home Health: 5 metrics each)
- Transparent reporting to create healthy competition and collaboration within the network
- Utilize Predictive Analytics (Heat Map)

ACO Contracts pushed us to be more robust in our understanding of data

But I'm not in an ACO:

- Try not to reinvent the wheel
  - MACRA MIPS Measures
  - CMS Core Measures 76 measures for Primary Care
- While you might have to track many measures for grants and other contracts, try to focus on a few high impact metrics

ACO Contracts Push Risk Coding

We had to learn to accurately capture and treat various diagnoses of our patients

- Hierarchical Condition Category (HCC)
- Episode Risk Group (ERG)
- Value Index Score (VIS)

Incorporate risk adjustments in metrics where possible

Utilize risk coding to standardized evidence based treatment models

ACO Contracts Push Risk Codding

But I'm not in an ACO:

- Risk Coding is still important
  - 34 States have participated in CMS State Innovation Model (SIM)
  - Partner with your MCOs to see if/how they are paid by risk.
- Incorporate risk adjustments in your metrics where possible otherwise you will encourage your staff to focus on less risky clients.
- Develop Care Pathways based on risk

ACO payment model forced us to look at Unnecessary Utilization

- HPN Opportunities Summary (Milliman Care Guidelines)
- All Cause Readmissions
- Emergency Department Continuing Care Plan
- Telehealth Consults in Emergency Departments
- Advanced Directives and Palliative Care
- In the process of developing medication formularies for providers

ACO payment model forced us to look at Unnecessary Utilization

But I'm not in an ACO:

- Partner with other local providers to reduce unnecessary utilization (Particularly your hospitals)
- Do what you can to lessen their burdens with your population particularly in the Inpatient Psych Unit, Emergency Department, Pain Management Clinics, Neurology, OB, PCPs, etc.
- If done well this will lead to increased behavioral health outpatient utilization offset by inpatient costs.

Develop Minimal Standards for existing and new ACO Network Partners

- Third Next Appointment Availability
- 7 day follow up post hospitalization (Psych and Family Medicine)
- All Cause Readmission Rates
- ED Utilization per 1,000
- Avoidable ED Encounters
- Depression Remission

Develop Minimal Standards for existing and new ACO Network Partners

But I'm not in an ACO:

- Develop your own internal minimum standards for your providers, clinics, etc.
- Allow high performing providers coach others.

Questions?

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